

OVERVIEW OF HEALTH ISSUES FACING MICHIGAN SENIORS

Presentation to the Michigan House of Representatives
Senior Health, Security & Retirement Committee
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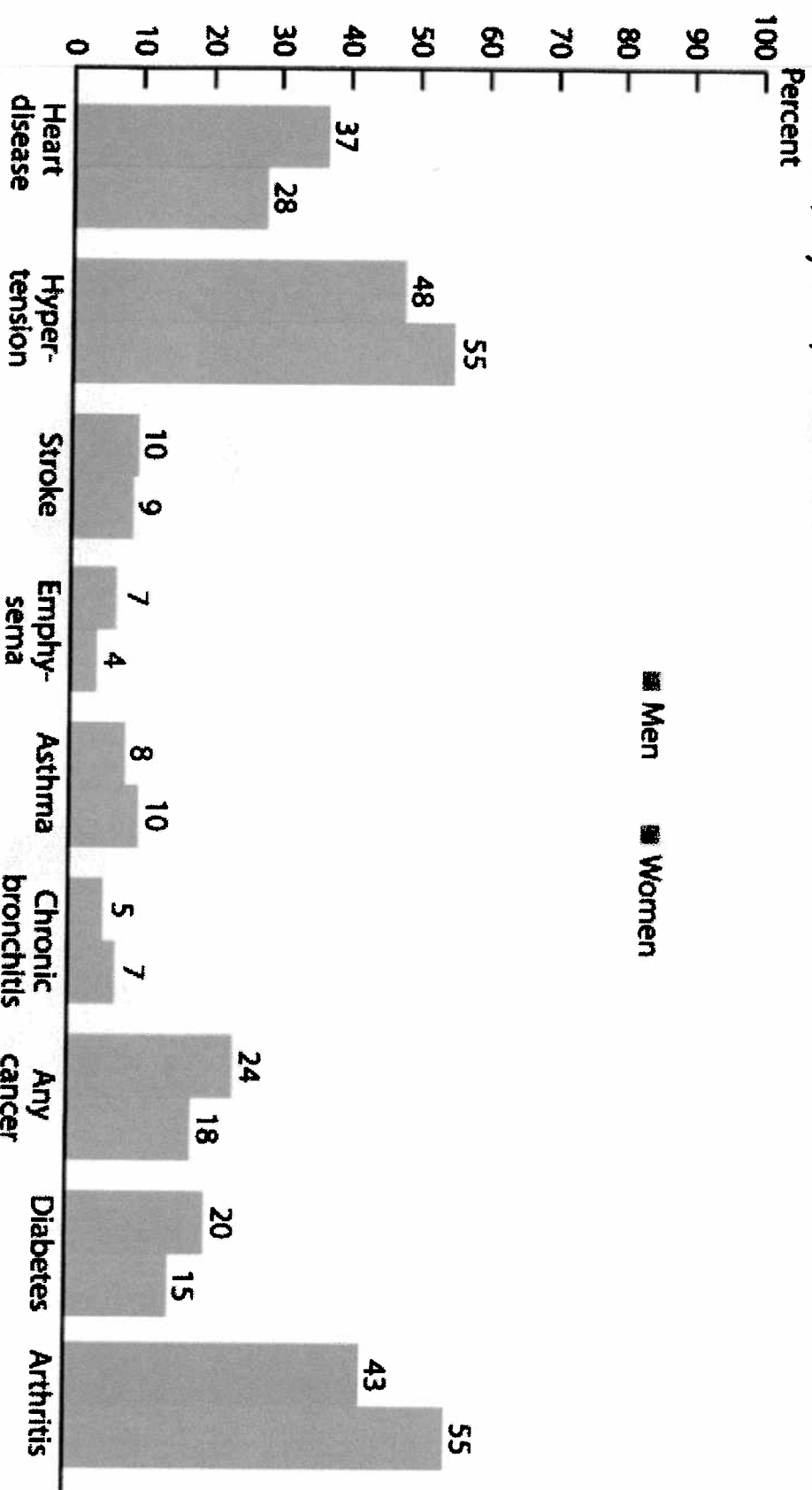
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PRESENTATION OUTLINE

- Prevalent Health CONDITIONS
- Conditions versus Disability = NEEDS
- Demographics Predicting Levels of Need
- Social, Cultural & Economic Dimensions
- Birth of an ISSUE: When Needs go UNMET = 4 Major Michigan Healthcare Issues
- Perspectives & Current Michigan Policy Responses

Health Conditions
(you know, the medical stuff)

Percentage of people age 65 and over who reported having selected chronic conditions, by sex, 2003-2004

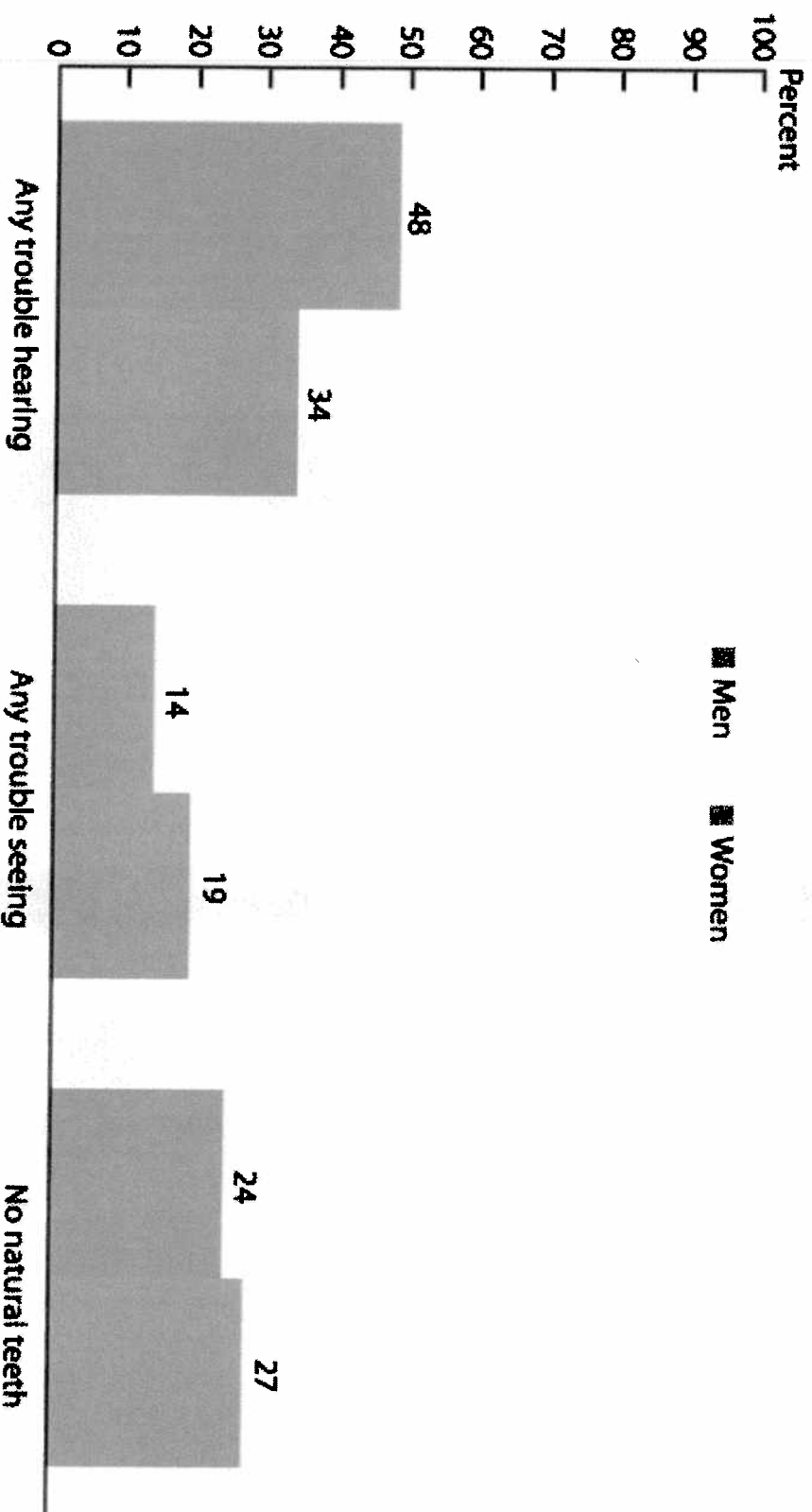


Note: Data are based on a 2-year average from 2003-2004. The question used to estimate the percentage of people who report having arthritis is "Have you EVER been told by a doctor or other health professional that you have some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia?" This differs from the questions that were asked to estimate the percentage of people who report having "arthritic symptoms" in *Older Americans 2004*.

Reference population: These data refer to the civilian noninstitutionalized population.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

Percentage of people age 65 and over who reported having any trouble hearing, any trouble seeing, or no natural teeth, by sex, 2004

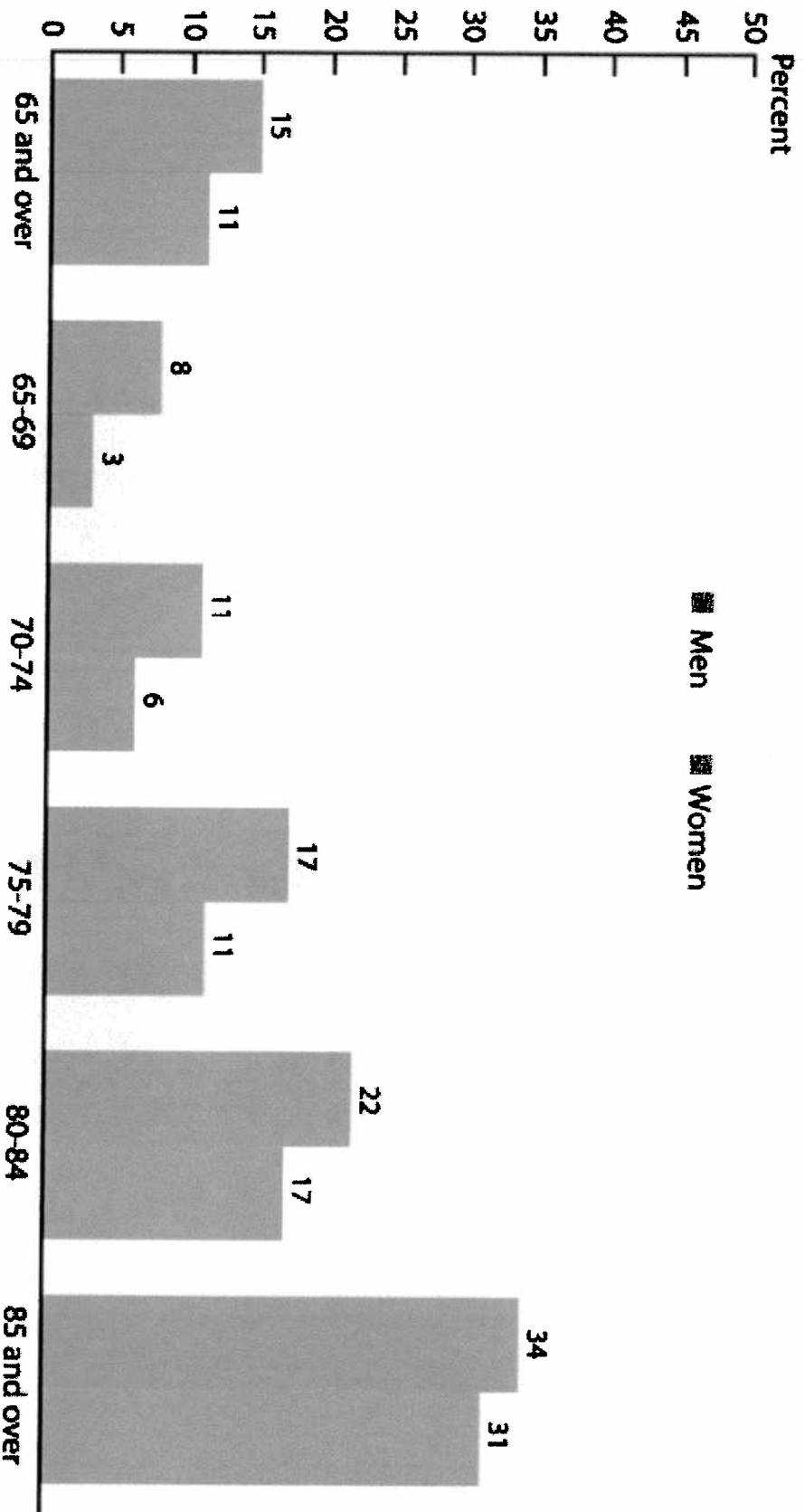


Note: Respondents were asked "Which statement best describes your hearing without a hearing aid: good, a little trouble, a lot of trouble, deaf?" For the purposes of this indicator the category "Any trouble hearing" includes "a little trouble, a lot of trouble, and deaf." Regarding their vision, respondents were asked "Do you have any trouble seeing, even when wearing glasses or contact lenses?" The category "Any trouble seeing" also includes those who in a subsequent question report themselves as blind. Lastly, respondents were asked, in one question, "Have you lost all of your upper and lower natural (permanent) teeth?"

Reference population: These data refer to the civilian noninstitutionalized population.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

Percentage of people age 65 and over with moderate or severe memory impairment, by age group and sex, 2002

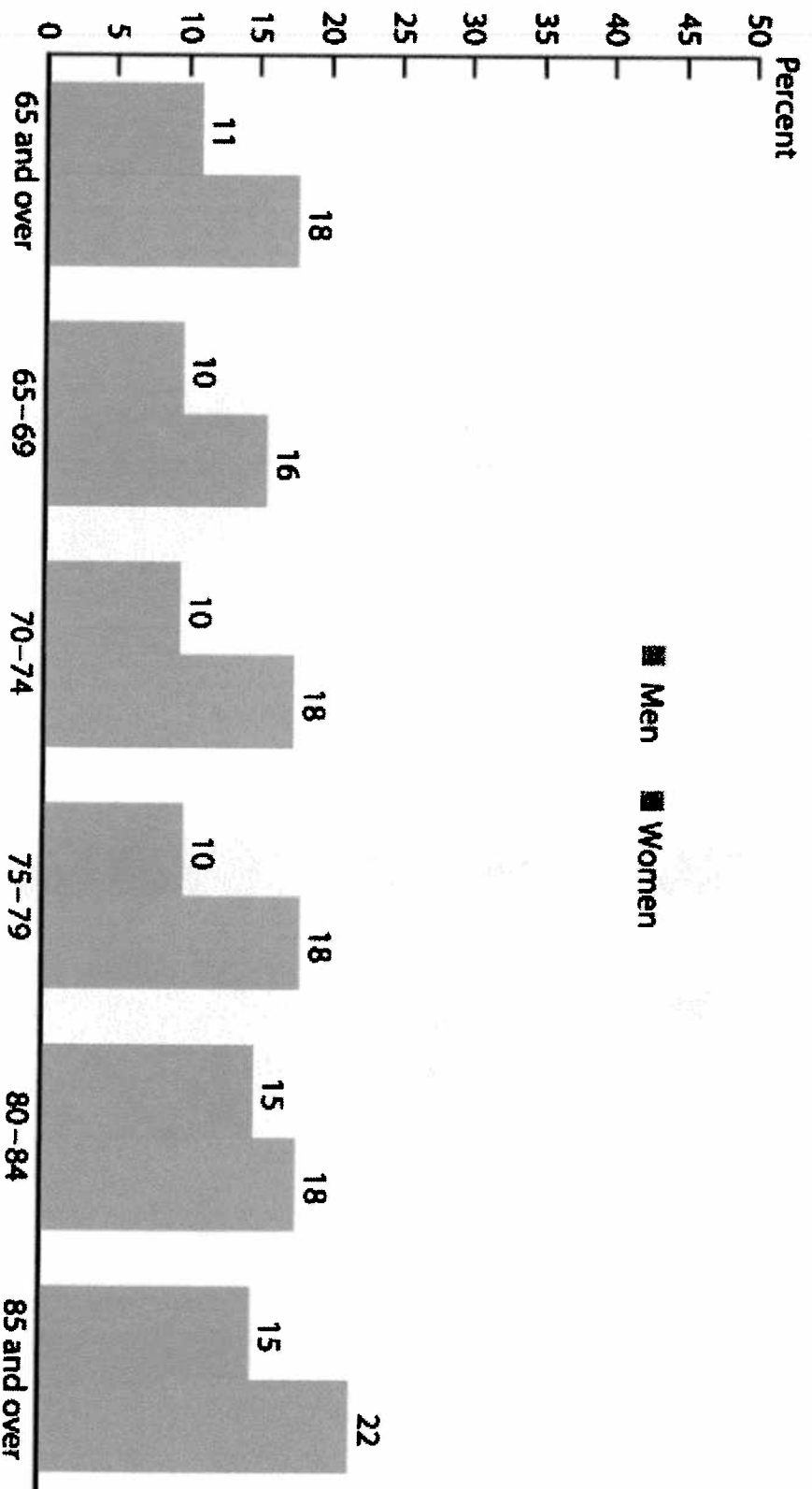


Note: The definition of "moderate or severe memory impairment" is four or fewer words recalled (out of 20) on combined immediate and delayed recall tests among self-respondents. Self-respondents who refused either the immediate or delayed word recall test were excluded from the analysis. Proxy respondents with an overall memory rating of "poor" were included as having moderate or severe memory impairment. Because of some changes in methods from the 2000 edition of *Older Americans*, no inference should be made about longitudinal trends.

Reference population: These data refer to the civilian noninstitutionalized population.

Source: Health and Retirement Study.

Percentage of people age 65 and over with clinically relevant depressive symptoms, by age group and sex, 2002



Note: The definition of "clinically relevant depressive symptoms" is four or more symptoms out of a list of eight depressive symptoms from an abbreviated version of the Center for Epidemiological Studies Depression Scale (CES-D) adapted by the Health and Retirement Study. The CES-D scale is a measure of depressive symptoms and is not to be used as a diagnosis of clinical depression. A detailed explanation concerning the "4 or more symptoms" cut-off can be found in the following documentation, hsr.nhanh.edu/docs/user/gdr-005.pdf.
Reference population: These data refer to the civilian noninstitutionalized population.
Source: Health and Retirement Study.

Causes of Death in Michigan in 2004

- Infectious & Parasitic Diseases (including TB) = 1,565
- All Cancers = 19,654
- Diabetes Mellitus = 2,954
- Malnutrition = 123
- Major Cardiovascular Diseases = 32,207
- Pneumonia & Flu = 1,959
- Lower Respiratory Diseases = 4,246
- Stomach & Duodenum Ulcers = 127
- Liver Disease = 972
- Kidney Disease = 1,511
- Pregnancy & Childbirth Related = 994
- All Other Diseases & Ill-Defined Conditions = 13,332
- Accidents = 3,299 (+50% motor vehicle)
- Suicide = 1,096
- Homicide & Legal Intervention = 672
- All Other External Causes = 411
- **YEAR TOTAL = 85,122**

(MDCH Figures)

Alzheimer's Disease Facts & Figures 2007 reported by the Alzheimer's Association for Michigan:

State Prevalence - based on state estimates for 2000, population projections from the U.S. Census Bureau, and state-specific adjustments for gender, race, education and mortality:

Michigan Alzheimer's disease 180,000 by 2010

Mortality

Alzheimer's disease is the 7th leading cause of death for people of all ages, and the 5th leading cause of death in people age 65 and older.

Number of Deaths Due to Alzheimer's Disease and Rate per 100,000 Population, 2003:

Michigan 2,133 deaths 21.2 %

Conditions and Their Potential Translations into Needs = Disabilities

Disability Rates	State	Rank	U.S.
Persons age 65+ with disabilities (%), 2005			
Sensory disability	16	28	16
Physical disability	31	17	31
Mobility disability	17	17	17
Self-care disability	9	19	10
Cognitive/mental disability	11	20	11
Any disability (one or more of the five listed above)	41	19	40
Cognitive/mental disability + any other disability	9	25	10
Persons age 50-64 with disabilities (%), 2005			
Any disability	19	20	19
Cognitive/mental disability + any other disability (one or more of the other four listed above)	5	13	5
Projected change in disability rate age 65+ due to economic and demographic factors (%), 2005-2020	-0.7	27	-0.6
Persons with Alzheimer's disease, 2000	170,000	8	4,700,000
Projected increase in the number of persons with Alzheimer's disease (%), 2000-2025	+12	45	+38

AARP 2006 Across the States Data

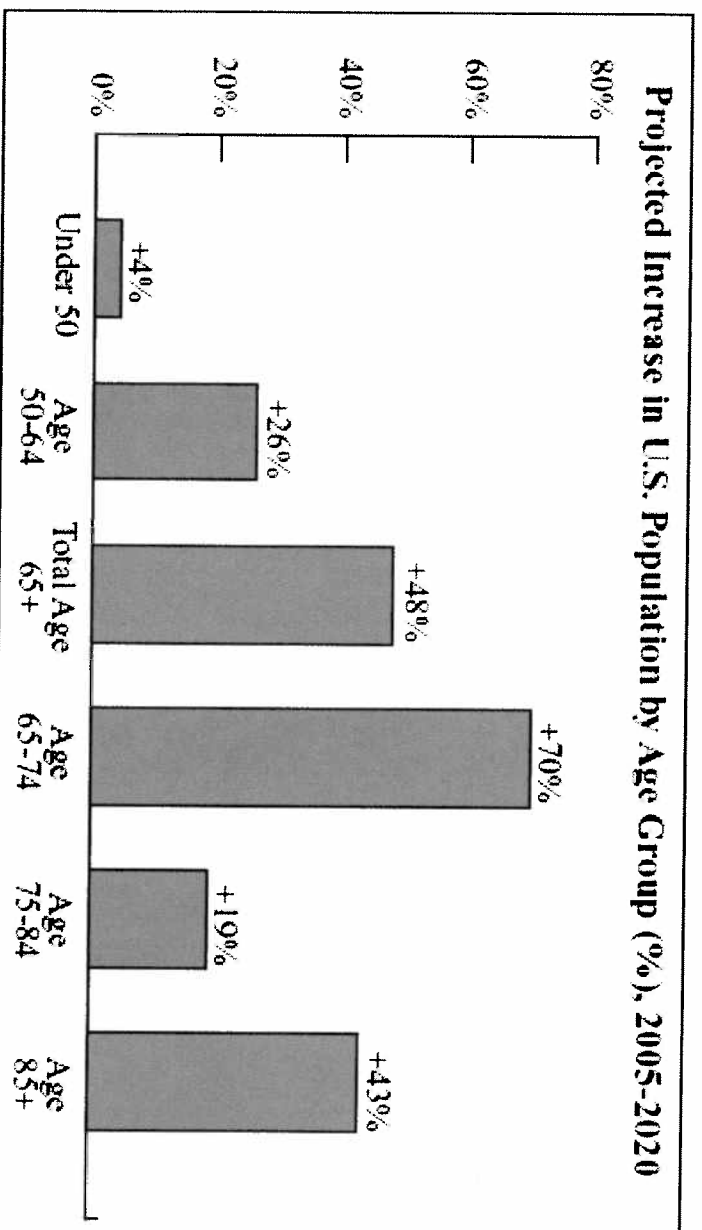
Tsunami – *NOT* the Movie

Aging Demographics

Pixel the Wave of Potential Need

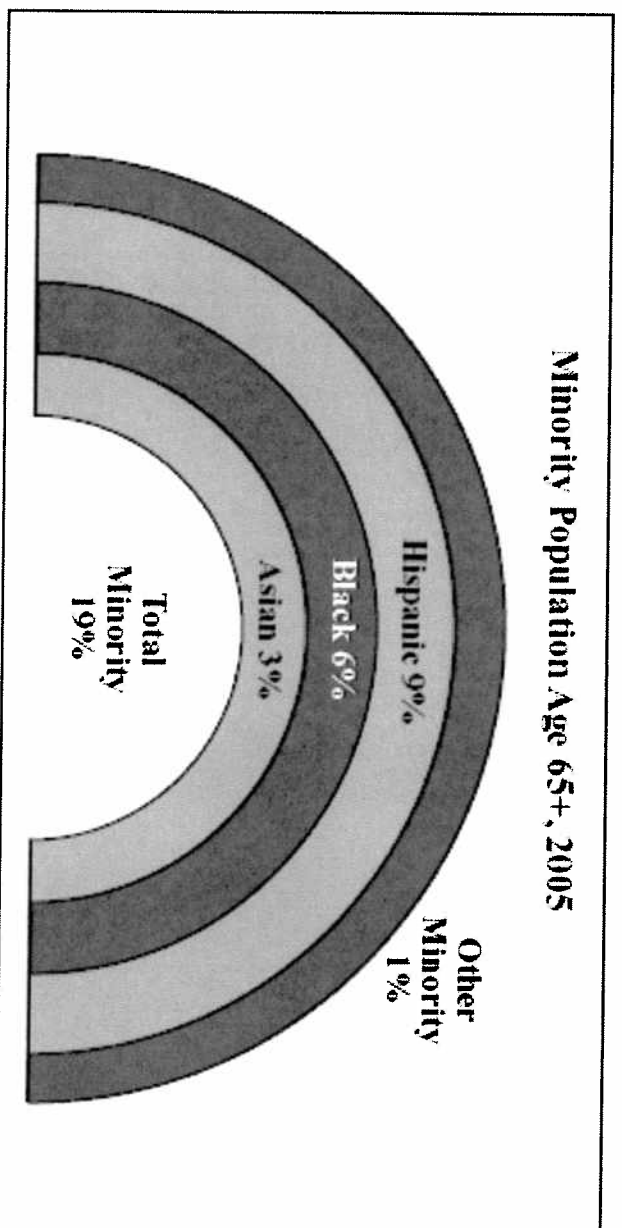
AGING POPULATION & PROJECTIONS

From 2005 to 2020, the population age 65 or older and the population age 85 or older will increase by almost one-half (48% and 43% respectively), and the youngest seniors age 65 to 74 will increase by 70%.



Data Source: U.S. Census Bureau Estimates (2005) and Projections (2020)

Not only is America aging, but the aging population is racially and ethnically diverse, with 19 percent of people age 65+ reporting that they are non-white or Hispanic.



Data Source: U.S. Census Bureau Estimates.

Minority aging populations in **Hawaii** (Asian) and the **District of Columbia** (Black) outnumber whites. More than one out of the three older people in **New Mexico, California, and Texas**—the states with the highest proportion of Hispanic elders—define themselves as minorities.

Michigan

POPULATION & PROJECTIONS

Age Groups	Year		State	Rank	U.S.
Total population (thousands)	2005	10,121	8	296,410	
	2020	10,696	10	335,805	
	% change	+6	32	+13	
Age 50-64 (% of all ages)	2005	17.5	26	17.0	
	2020	19.3	23	18.9	
	% change	+16	28	+26	
Age 65+ (% of all ages)	2005	12.4	31	12.4	
	2020	16.0	35	16.3	
	% change	+36	34	+48	
Age 65-74 (% of all ages)	2005	6.0	40	6.3	
	2020	9.3	34	9.5	
	% change	+62	30	+70	
Age 75-84 (% of all ages)	2005	4.6	18	4.4	
	2020	4.6	32	4.6	
	% change	+5	39	+19	
Age 85+ (% of all ages)	2005	1.8	21	1.7	
	2020	2.2	23	2.2	
	% change	+26	41	+43	

**Needs Are People Too:
Socioeconomics Predict Who Surfs
vs. Those Pulled Under**

Race & Ethnicity	State	Rank	U.S.
Minority age 65+ (%), 2005	12.8	24	18.5
Asian age 65+ (%), 2005	1.0	24	3.2
Black age 65+ (%), 2005	9.9	14	8.6
Hispanic age 65+ (%), 2005	1.3	31	6.2

Population Characteristics	State	Rank	U.S.
Men per 100 women age 85+, 2005	44	29	46
Persons age 75+ living alone (%), 2005	39	25	38
Non-metropolitan population age 65+ (%), 2006	19	33	20
Bachelor level education or higher age 65+ (%), 2005	15	36	18
Grandparents age 60+ raising grandchildren (%), 2005	1.3	33	1.6
Caregivers (% of all adults age 18+), 2000	16.5	6	15.6

Note: The highest data value within each ranking is indicated by a rank of "1"
The percent change calculations on this page are based on the total population in each age group. For example, the U.S. population age 65+ was 36,790,113 in 2005 (12.4% of the total population) and was projected to be 54,631,891 in 2020 (16.3% of the total population). These numbers represent a 48% increase in the age group population between 2005 and 2020.

Housing & Transportation	State	Rank	U.S.
Homeownership rate age 65+ (%), 2005	83	12	79
Homeowners age 65+ paying 30% of income or more for housing (%), 2005	26	16	26
Renters age 65+ paying 30% of income or more for housing (%), 2005	51	20	54
Persons age 65+ in housing built before 1960 (%), 2005	45	15	38
Persons age 65+ without a vehicle in household (%), 2005	10	17	12

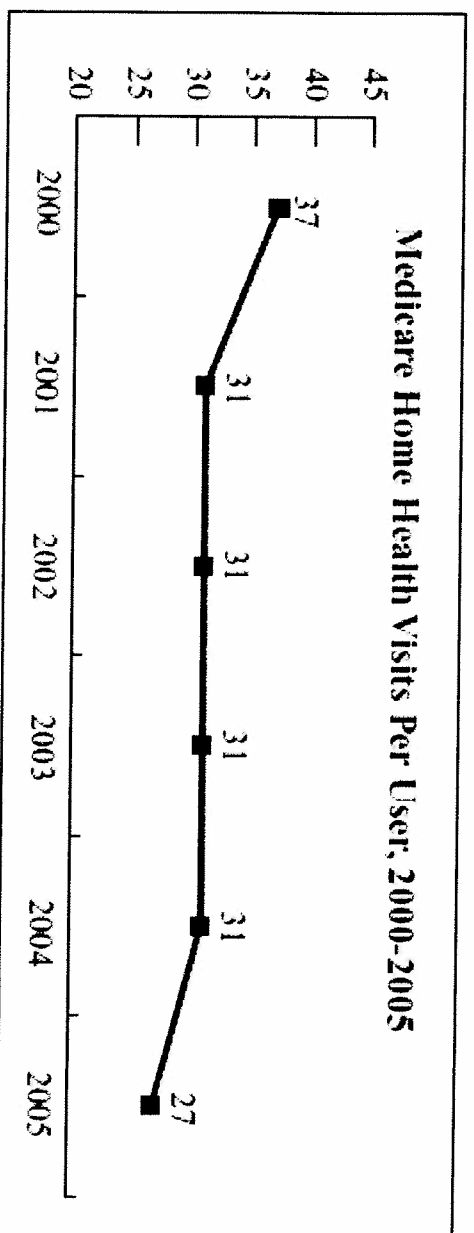
Income & Poverty	State	Rank	U.S.
Median household income age 65+, 2005	\$28,200	25	\$28,722
At/below poverty level age 65+ (%), 2005	8.3	35	9.9
At/below 200% of poverty level age 65+ (%), 2005	32	31	34
At/below 300% of poverty level age 65+ (%), 2005	55	23	54
Women age 75+ at/below poverty level (%), 2005	11	36	14

**When Needs are Not Met
= Now You have Health Issues**

**Issue #1: Access & Affordability
or, Crumbling Levees
& Increasingly Low-Lying Areas
in Our Health & Safety Net Infrastructure**

Ten states did not provide any Medicaid or other state-funded public financing for persons in group residential care settings in 2004, and many states had HCBS waiver waiting lists during that same year.

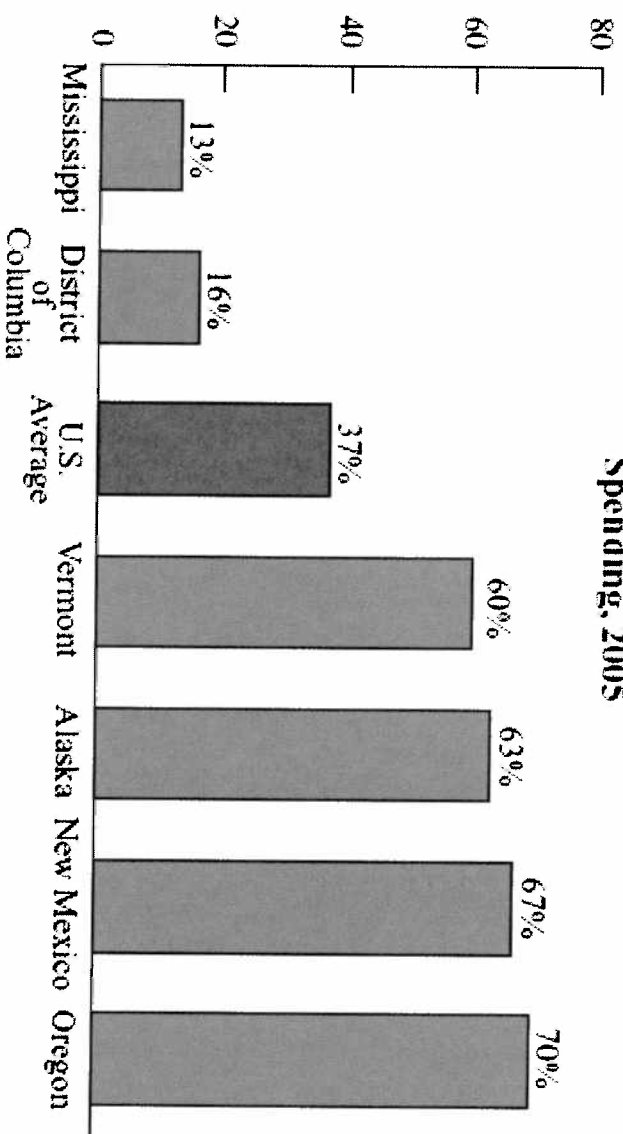
While Medicaid HCBS utilization has increased, Medicare home health visits per user decreased 26% between 2000 and 2005.



Data Source: Centers for Medicare and Medicaid Services, *Medicare & Medicaid Statistical Supplement* (2000-2002) and *Medicare Home Health Utilization by State* (2003-2005).

The average home health user received 27 home health visits in 2005, a reduction from 37 visits per user in 2000. In fact, every state experienced a decrease in Medicare visits per user. This decrease is significant because Medicare is the major payer for skilled home health care.

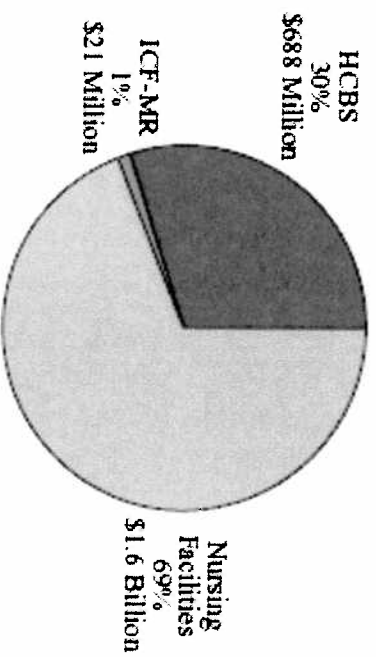
Medicaid HCBS Spending as a Percentage of Medicaid Long-Term Care Spending, 2005



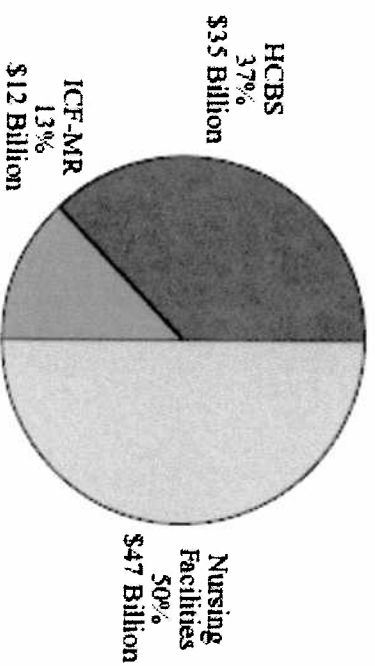
Data Source: Burwell, Siedl, & Eiken. *Medicaid Long Term Care Expenditures FY 2005*. Thomson-Medstat.

Medicaid Spending on Long-Term Care Services, by Type of Service, 2005

Michigan

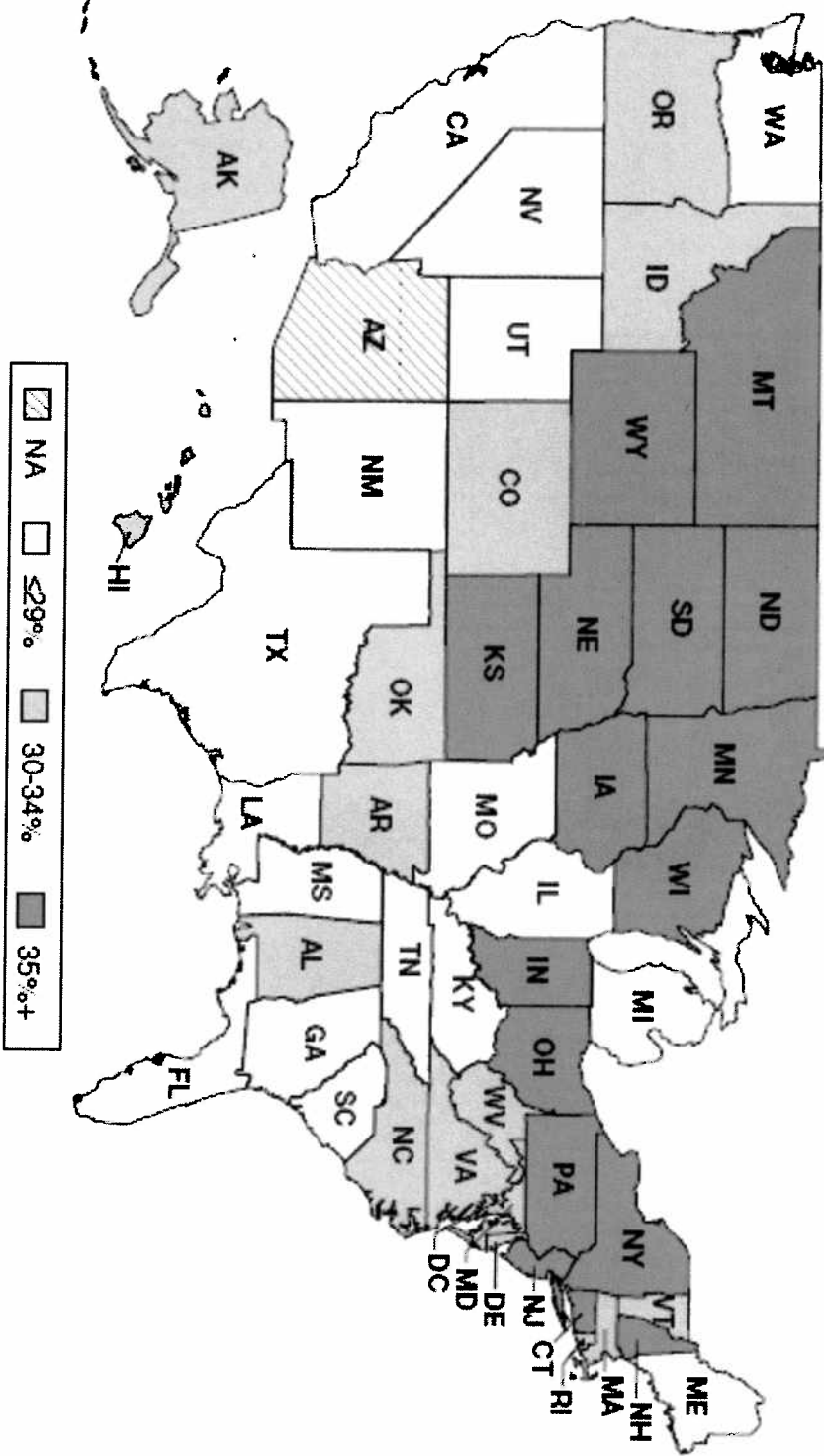


United States

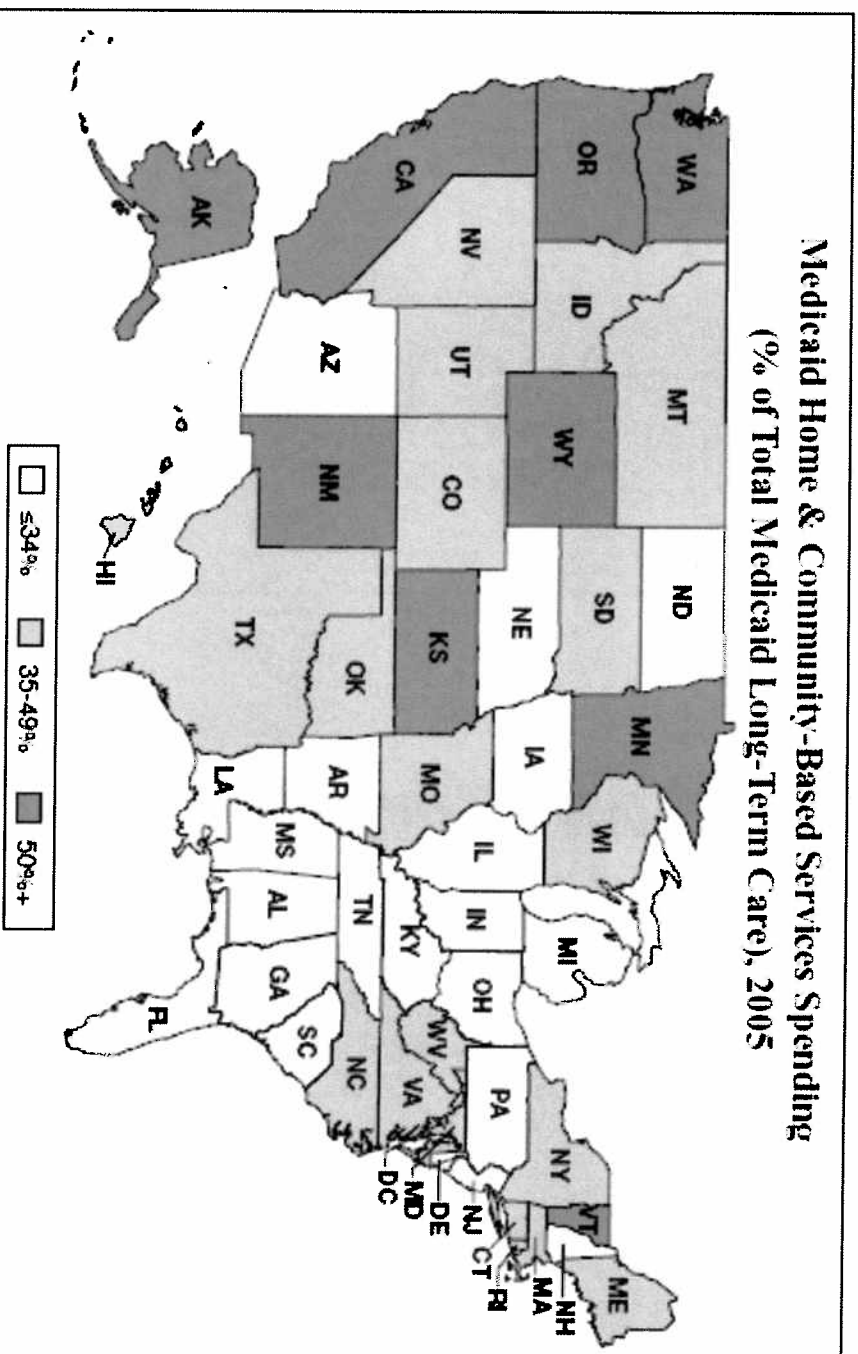


AARP 2006 Across the States Data

Medicaid Long-Term Care Spending (% of Total Medicaid), 2005



Medicaid Home & Community-Based Services Spending (% of Total Medicaid Long-Term Care), 2005



Data Source: Butwell, Sredl, & Eiken, *Medicaid Long Term Care Expenditures FY 2005*, Thomson-Medstat.

Medicaid nursing facility care costs more than twice as much as HCBS. Medicaid spending per HCBS recipient was about \$10,500 in 2002, and spending per nursing facility beneficiary was about \$24,000 in 2003. In comparison, Medicaid spending per *aged/disabled* waiver recipient was about \$7,300 in 2002.

Use of HCBS	State	Rank	U.S.
Medicare beneficiaries receiving home health services (%), 2005	9.6	8	7.3
Medicare home health visits per user, 2005	22	23	27
Medicaid HCBS participants, 2002	74,784	8	2,376,454
Medicaid HCBS participants per 1,000 population, 2002	7.5	25	8.3
Home health	0.6	41	2.7
Personal care*	5.1	4	2.4
HCBS waiver services	1.8	42	3.2
Aged/disabled waiver services	0.9	39	1.8
Medicaid aged/disabled waiver participants per 100 beneficiaries in nursing facilities, 2002	20	35	30
Persons in group residential care settings covered by Medicaid and state-funded public financing, 2004	14,138	3	122,421

Issue #2: Access by Another Name

-- namely, Where's "The Help"?

The Direct Care Worker Shortage

CRISIS

-- How Even Cadillac Owners are

Finding their Cars on Cinder Blocks

The Direct Care Worker Shortage Crisis

- **Wages are low**
- **Access to health benefits is very limited**
- **Training and supervision is inadequate**
- **The work itself is dangerous**

Michigan's Care Gap: Our Emerging Direct-Care Workforce Crisis by Hollis Turnham & Steven Dawson, Paraprofessional Healthcare Institute, 2003

Wages Are Unattractive

In 2001, the average wage of a Michigan direct-care worker was just \$9.26 per hour—substantially less than the average wage of \$17.31 per hour in Michigan. Michigan car mechanics earn \$17.55 an hour, aerobic instructors average \$12.57 an hour in the state, and dog trainers are paid \$10.34 an hour in Michigan (BLS 2001a).

Table 3: Average Hourly Wage Comparisons With Other Jobs

Job Category	Average Wage/Hour
Direct Care Worker	\$ 9.26
Car Mechanic	\$17.55
Aerobics Instructor	\$12.57
Dog Trainer	\$10.34
Statewide average wage of all workers	\$17.31

Direct-care workers earn less than 55 percent of the average workers' wage across the state.

Even after working a 40-hour work week, the average direct-care worker in Michigan with two children is income-eligible for food stamps.

Michigan's Care Gap: Our Emerging Direct-Care Workforce Crisis by Hollis Turnham & Steven Dawson, Paraprofessional Healthcare Institute, 2003

Little or No Health Care Coverage for Health Care Workers

- Our largely publicly-funded long-term health system fails to ensure its own workers' health coverage.
- Many long-term care providers do not offer health coverage to their workers.
- Those that do often charge premiums too high and/or offer it only to full-time staff = 70% of workers still do not have coverage as a result.
- Dependents' coverage may be limited.

Training Is Not Adequate and Career Advancement Opportunities Are Rare

- The highest initial training requirement in the entire long-term care sector mandates 75 hours for nursing home workers in Medicare and Medicaid certified homes – not nearly enough – 26 states require more and 13 states require a minimum of 100 hours; Michigan operates at the federal minimum.
- Federal law requires home health aides to be “competency evaluated” in 12 areas and levels to work in Medicare and Medicaid certified agencies, but leaves it to states to determine whether this evaluation is performed before or after hire – Michigan allows HHAs to hire workers who can pass the test without training – so some Michigan HHAs hire only those who complete the 75 hour nursing home training; Michigan is also one of the remaining states that does not license HHAs.
- Many other direct care workers can legally begin working in many areas of the system without any training whatsoever, such as Home Help workers, Home for the Aged staff and Personal Care Aides (PCAs); workers hiring into licensed Adult Foster Care Homes must learn first aid, fire safety, CPR, resident rights and reporting, and, “personal care, supervision and protection” services.
- Michigan’s Home Help and MiChoice workers are as dissatisfied with their lack of “promotion opportunities” as they are with their wages.

Workloads Are Dangerous

- Understaffed health services settings put more pressure on existing staff, working excessive hours (including extra shifts) and taking more risks while at greater sustained levels of fatigue.
- Michigan's nursing home workers experience the 4th highest rate of injuries of all industries in the state.
- Much ongoing exposure to communicable diseases of “patients” (including auto-immune disorders) while fatigue levels reduce resistance.

ISSUE #3: Healthcare Disparities = When People are NOT People Too

- “Unintended” racism and additional institutionalized policies and practices by clinicians, providers, communities and the market cause significantly lower diagnostic rates, reduced level and numbers of treatment orders, follow up and access especially for African Americans as well as other racial minorities. Mortality rates for African Americans in Detroit far exceed anywhere else in the United States and rival many across the globe.
- Similarly operating prejudices cause clinicians and systemic practices to confuse physical and/or mental *disability* with *disease* conditions, spiking medical error rates and possible malpractice among these populations.
- Gender inequities cut in multiple directions.
- Pernicious ageism’s impact also parallels and intersects with the other prejudices – and it’s not just the kids!
- Newer restrictions on health services and coverage for legal immigrants maintain poorer health and worse access outcomes for these communities...likewise shifting more costs to....

Issue #4: It Used to be

“It’s the Economy, *Stupid!*”

Now It’s

“Healthcare IS the Economy,
Grasshopper”

OR: If you think Michigan’s

Economy is in Poor Health, well...

Economic Impact of Michigan Healthcare

- Healthcare is Michigan's largest employer and the only major industry sustaining growth during the state's overall long-term loss of jobs. Of the approximately 850,000 healthcare and related jobs in Michigan, well over 600,000** such positions are sustained locally directly as a result of Medicaid funded services: cutting Medicaid does not "reduce Government*", it eliminates jobs.
- Last year Medicaid eclipsed Medicare as the nation's largest single payer for health services.
- 1.5 Michiganians receive Medicaid services per month – 1.6 million when combined with MIChild and Adult Medical Programs = easily 10% of our entire state population.
- 75% of Medicaid recipients are low-income families with children, whose average Medicaid cost nearly equals the annual salary of a low-wage job = \$9,763.
- Every State dollar put into of the Medicaid Program generates another \$1.30 in health services from the federal government = the single largest federal dollar return in Michigan's entire State budget; so cutting State Medicaid throws more than twice that amount in public incoming revenue away.
- *Medicaid's efficiency in delivery of health services coverage statewide per person is \$3,800, whereas as General Motors costs \$4,400, Chrysler costs \$4,800 and Ford costs \$5,700; meanwhile these historic and uniquely Michigan employers are losing ground in global competitiveness in great part due to health costs.
- Meanwhile nearly **12.7%** of Michigan's entire population struggles daily to provide health support and services with no help form any public or private program whatsoever – making an economic impact on Michigan communities that eclipses **\$13.4 Billion annually** (\$350 billion nationally) – while undermining existing careers and productivity.
- **See the attached table which breaks out Medicaid healthcare expenditures and jobs sustained in each Michigan county.

Data from the Michigan League for Human Services & AARP

FY2005 Total Medicaid, Michild and Adult Benefits Waiver Spending and Total Health Care Jobs, by County

County		Total Medical Spending	Total Number of Health-Care Related Jobs	County		Total Medical Spending	Total Number of Health-Care Related Jobs	County		Total Medical Spending	Total Number of Health-Care Related Jobs
Entire State		\$7,860,976,300	605,240								
Alcona		\$9,576,700	383	Houghton		\$37,453,100	2,303	Muskegon		\$180,567,600	10,575
Alger		\$7,336,800	370	Huron		\$36,228,500	1,973	Newaygo		\$42,625,000	1,395
Allegan		\$72,179,900	2,342	Ingham		\$199,499,600	22,687	Oakland		\$544,707,000	92,603
Alpena		\$30,990,300	2,271	Ionia		\$42,560,100	1,492	Oceana		\$28,018,400	473
Antrim		\$19,015,300	267	Iosco		\$28,092,300	1,691	Ogemaw		\$25,164,500	1,282
Arenac		\$18,710,800	1,091	Iron		\$21,328,500	767	Ontonagon		\$10,286,600	380
Baraga		\$9,670,800	686	Isabella		\$67,837,800	1,767	Osceola		\$21,457,900	497
Barry		\$34,894,600	2,255	Jackson		\$131,021,100	9,254	Oscoda		\$9,907,100	178
Bay		\$94,264,500	6,442	Kalamazoo		\$178,469,500	20,885	Osego		\$20,998,100	1,400
Benzie		\$14,375,800	530	Kalkaska		\$18,084,300	463	Ottawa		\$95,904,100	10,571
Berrien		\$156,158,600	9,278	Kent		\$423,518,700	46,311	Presque Isle		\$10,890,900	529
Branch		\$39,099,900	1,910	Keweenaw		\$3,048,100	50	Roscommon		\$26,522,200	691
Calhoun		\$140,334,800	9,422	Lake		\$15,734,900	665	Saginaw		\$219,838,000	18,930
Cass		\$39,121,000	935	Lapeer		\$49,001,000	2,411	St Clair		\$110,995,700	8,836
Charlevoix		\$17,419,100	767	Leelanau		\$7,209,800	561	St Joseph		\$54,898,800	2,607
Cheboygan		\$23,924,700	1,378	Lenawee		\$66,026,600	3,713	Sanilac		\$39,966,500	1,716
Chippewa		\$29,554,300	1,629	Livingston		\$50,143,600	4,183	Schoolcraft		\$11,245,100	450
Clare		\$35,802,400	1,270	Luce		\$8,236,500	359	Shiawassee		\$57,293,700	2,833
Clinton		\$26,729,400	1,702	Mackinac		\$10,271,500	318	Tuscola		\$46,949,600	2,572
Crawford		\$14,277,500	1,166	Macomb		\$428,156,800	35,016	VanBuren		\$75,842,100	2,624
Delta		\$37,221,100	2,094	Manistee		\$23,968,700	1,154	Washtenaw		\$138,832,800	34,590
Dickinson		\$25,516,300	2,858	Marquette		\$52,559,000	7,435	Wayne		\$2,290,635,900	117,053
Eaton		\$53,906,900	2,513	Mason		\$24,859,300	1,656	Wexford		\$31,517,800	1,805
Emmet		\$26,305,800	3,784	Mecosta		\$33,274,300	3,636	Note: Medical spending estimates by county provided by the Michigan Department of Community Health. Health care jobs include include direct health care jobs and indirect/induced jobs as reported in the The Economic Impact of Health Care in Michigan, Partnership for Michigan's Health, June 2004.			
Genesee		\$415,526,700	31,303	Menominee		\$21,183,000	2,556				
Gladwin		\$26,232,300	837	Midland		\$52,934,400	5,722				
Gogebic		\$21,341,300	806	Missaukee		\$10,576,400	329				
Grand Traverse		\$60,565,100	9,126	Monroe		\$83,097,400	4,627				
Gratiot		\$41,479,200	2,293	Montcalm		\$48,234,900	2,766				
Hillsdale		\$41,013,100	1,718	Montmorency		\$10,755,900	479				

The Higher Costs of Not Paying For It

- Hospital ER over-utilization and other non-reimbursed services in nursing homes and elsewhere accelerating facility closures = this cost of business putting more of the healthcare industry out of business.
- The sheer and sharply-rising expense of providing healthcare benefits is causing increasing numbers of our largest – let alone smaller – employers to significantly reduce or eliminate these benefits entirely, take their business to other states or countries, or, go out of business entirely as well.
- Uninsured and underinsured – **70% of whom are working people**, by the way – are delaying or foregoing diagnoses and treatment = more people entering what system exists at higher and more costly levels of need with fewer possibilities for positive and less-costly outcomes.
- Vast, trans-systemic fragmentation across multiple private and public sectors imbeds and sustains cost duplications and inefficiencies.
- One major result is while the United States spends far more on healthcare than any other industrialized nation, it delivers comparatively the least healthcare services of these nations, resulting in the *worst health outcomes* in the industrialized world.
- The same, vast, trans-systemic and sector fragmentation also defies significant “purchase” of quality and affordability improvements pursued via incremental solutions, or from policy-making which addresses only the “edges.” Indeed, much of the resulting and growing fragmentation stems directly from the history of incremental policy-making itself.

Add 'Em Up

Issues 1 + 2 + 3 + 4

= Ten Times the Need for Solutions

Senior Health Issues are:

-- Not Just for Seniors Anymore but are
EVERYONE's

-- Involve Awareness that Health Issues We Share
go Way Beyond our Bodies

-- Include Awareness that Personal Responsibility
Requires a True Health & Long Term Care
Infrastructure to Assure Access

-- Just Another Wording for Nothing Left to Lose
...an Old Song Indeed.

Perspectives on “Senior Health Issues”

- Health, access to services and affordability issues differ little based on age. Some statistical increases in some areas of outcomes align with increasing age, previous and acquired disability, and, socio-economic factors.
- “Future” needs of seniors = Us and our adult children = Choice + Quality + Affordability + Security.
- Health Policy = Economic Policy: health investment and reform = jobs = consumer access + provider quality = improved health + fiscal + quality of life outcomes = a strengthened economy.
- The current health system is broken:
 - continuing erosion of employer-based insurance and pensions
 - emaciation of Medicare reimbursement to doctors and other providers cutting off even Medicare access as drop-outs accelerate
 - significantly greater access barriers to existing Medicaid covered services due to far worse reimbursement rates and long term budget appropriations attrition at state and federal levels
 - bewildering system wide fragmentation of public and private administration, payment and regulation
 - 46 million and growing uninsured Americans, 29 million of which report skipping treatment, tests or prescriptions due to costs
- If the “American Dream” is a function of people being able to assure they have the ways, means and personal capacity – via fully MET health needs – to pursue their Happiness, we can begin to see how a broken health care system directly undermines American freedom, our homeland security and the resulting strength of our nation. Leaving people “free” to fend for their own healthcare has not kept them free, nor has it delivered health, a healthy economy or made us a more united country.
- Fracturing and fragmenting political processes at the state and national level, mirroring our healthcare non-system and maintaining legislative gridlocks, continues to not solve problems of people, economies and quality of life in our society; this may well be the greatest “senior health issue” requiring treatment and a cure. Fortunately that may cost nothing at all but leadership possessing the political will and vision of a more united Michigan and country.

Current Directions in Health Reform

- States' experimenting with covering the uninsured.
- Michigan's proposals: the Governor's Michigan Health First Initiative and Senate Bills 278, 280 and 283 ("MI-HEART Act") "Exchange" provisions.
- 2005 Michigan Medicaid Long Term Care Task Force Final Report Recommendations.
- Executive Order #2005-14 and the Michigan Department of Community Health Single Point Entry Demonstrations within the Office of Long Term Care Supports & Services.
- Budget threats to Medicaid, if carried out, will destroy all the above unless a new System is enacted.

RESOURCES

- *Modernizing Michigan Medicaid Long-Term Care -- Toward an Integrated System of Services and Supports*, the Final Report of the 2005 Michigan Medicaid Long Term Care Task Force and other information on the many efforts to reform long term care undertaken through the Michigan Office of Long Term Care Supports and Services: at <http://www.michigan.gov/ltc>.
- www.aarp.org
- AARP Michigan site: <http://www.aarp.org/states/mi/>
- AARP Associate State Director for Government Affairs, Bill Knox: (517) 267-8917 WKnox@aarp.org